The Association of Directors of Public Health

Response to the Health Committee Inquiry into The First 1000 Days of Life

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

The Association has a rich heritage, its origins dating back 160 years. It is a collaborative organisation working in partnership with others to maximise the voice for public health.

Summary

The ADPH welcomes the opportunity to respond to the Health Committee's inquiry into the First 1000 Days of Life. ADPH advocates for a whole system approach to ensuring better outcomes for children, including during the first 1000 days of life, with joint working between the local authorities, education, the NHS, housing, social services, planning, voluntary, police and youth justice sectors. It is critical that children receive early and high-quality public health interventions to give them the best start in life. We would welcome the opportunity to give oral evidence to the Committee.

Recommendations

- **Government should take a whole system approach to children and young people's health and should adopt a 'health in all policies' approach to decision-making and policy. This should include emotional health, resilience and mental health as integral.**
- **National targets to reduce child poverty should be restored.**
- **Health and social care professionals including GPs, midwives, health visitors, family support workers and social workers should be trained to identity prenatal and perinatal maternal problems early, to enable a targeted offer of more individualised support and signposting for those families with the greatest needs.**
- **A whole family approach should be taken, that is proportionate to need, with a focus on positive parenting, to prevent and reduce the impact of adverse childhood experiences (ACEs). A national framework for addressing Adverse Childhood Experiences should be adopted.**
- **A long-term plan is required with the support of government, Public Health England and the NHS to change the culture of breastfeeding so that women feel socially supported to breastfeed. Childhood obesity prevention should focus on promoting a healthy pattern of growth in the early years.**
- **Investment in public health must be increased. Cuts to public health budgets must be reversed and public health needs to be funded fairly, sustainably and adequately in line with local population health need.**

- **The Government should mitigate the impact of wider local authority funding cuts on the health of children and young people; for example, cuts to children's services.**
- **The Government should review the reasons for the increasing number and cost of complex child placements and recognise the burden that this places on local authorities.**

1 National strategy

Below we set out ADPH's priorities for a national strategy to support the first 1000 days of life.

Whole-system approach

1.1. ADPH advocates for a whole system approach to improving child health. This requires joint working between the NHS, housing, education, social services, planning, voluntary, police and youth justice sectors. The current national approach to the First 1000 Days is fragmented – with budgets and responsibilities spread across the many Whitehall Departments. A coherent strategy is necessary to ensure joined-up approaches. This needs to be mirrored at a local level, building on the systems that are already in place – such as health and wellbeing boards – and enabling local leadership to meet local circumstances.

1.2. To make the case for the most effective interventions, a clear understanding about the level of prevention (primary, secondary, tertiary) and appropriate interventions for key health needs and population groups is required. Achieving prevention impact at a population level needs not only an emphasis on personal health and care and community engagement, but also population level policies, often referred to as a 'health in all policies' approach. To do this will require a range of partners to support the delivery of prevention from workplaces and schools to homes and hospitals.

1.3. Wales and Scotland act as good examples. In 2015, the Wellbeing of Future Generations Act was enacted in Wales. This similarly calls on public bodies to take a joined-up approach and work collaboratively with the population, communities and each other to support children and young people and prevent persistent problems such as poverty and health inequalities.

1.4. The Scottish Government published Getting it right for every child in 2010. The strategy encourages early intervention and calls on services that support children and young people, including social work, health, education, police, housing and voluntary organisations to work together. The Scottish Government is in the process of developing a ten-year Child and Adolescent Health and Wellbeing Action Plan which will take a rights-based approach.

1.5. Looking at the approaches to school-readiness helps to explain the policy divergence between the four nations. Policy approaches in Scotland and Wales appear more distinctly focused on setting a framework for dealing with wider determinants of child development, most particularly emphasising children's rights and the need to address poverty. Examples of divergence often reflect different national conceptualisations/approaches to early child development, e.g. whether it is framed as being about a child's learning in preparation for school (England) or about a child's learning journey, wellbeing and preparation for life

(Scotland). [1]

Recommendation: Government should take a whole system approach to children and young people's health and should adopt a 'health in all policies' approach to decision-making and policy.

Child poverty

1.6. Currently, one in five children across the UK are living in poverty and this is predicted to increase.[2] Childhood poverty is associated with adverse health, developmental, educational and long term social outcomes which can have lasting effects that continue into adulthood.[3] Issues associated with poverty such as housing problems and homelessness, food insecurity and financial stress contribute significantly to the ill-health of children.[4]

Recommendation: National targets to reduce child poverty should be restored.

Inequalities

1.7. Inequalities in early life can have a significant bearing on future health outcomes. There is a strong association between deprivation and mortality during childhood, with social inequalities affecting many of the leading causes of death among children and young people.[5] Children and young people living in the most deprived households are at greater risk of non-intentional injury compared to those living in the least deprived households, and this includes injury through poor and overcrowded housing infrastructure and poorer parental education in how to protect their children.[6] Children and young people growing up in deprived circumstances are also at greater risk of mental ill health and suicide,[7] tooth decay,[8] teenage conception[9] and being overweight or obese and, ultimately, premature death.[10]

1.8. The UK compares unsatisfactorily to countries of similar wealth for both infant and child mortality rates. In 2016 the infant mortality rate in England and Wales was 3.8 deaths per 1,000 births, compared with 3.7 in 2015. The perinatal mortality rate (stillbirths and deaths at age under seven days) was 6.6 deaths per 1,000 births, compared with 6.5 in 2015.[11]

Social determinants

1.9. It is important to make a distinction between tackling social inequality and preventing social inequality from having a negative impact on health outcomes. Both are extremely important but changing the levels of social inequality is mostly out of the gift of public health. Changes to fiscal policy, legislation and culture change mainly implemented at national level are likely to be the most powerful levers for reducing both social inequality and the impact of social inequality on health. However, actions that improve equity of access to services and facilities, and that focus on improving health in vulnerable groups, can make important contributions to preventing further increases in health inequalities.[12]Action is needed to improve social determinants of health that are modifiable such as the provision of good quality housing, access to healthy food, safe environments and good working conditions.

1.10. Poor perinatal mental health, being overweight or obese, and engaging in harmful behaviours such as smoking and alcohol consumption during pregnancy can affect bonding and have significant consequences for the child's development and health.[13] [14] In many areas of the UK there is a lack of access to Specialist Perinatal Mental Health Community Teams.[15] Depression and anxiety during pregnancy are both under-diagnosed and under-treated.[16]

1.11. The prevalence of smoking during pregnancy in the UK is higher than in many other European countries. ADPH welcomed the Tobacco Control Plan's commitment to reducing the prevalence of smoking in pregnancy from 10.7% to six per cent. NICE guidance should be implemented to reduce smoking during pregnancy, including carbon monoxide testing and opt-out referral processes.

1.12. More than 1.4 million children and young people in the UK have speech, language and communication needs (SLCN). Language disorder is one of the most common disorders of childhood, [17] affecting nearly 10%[18] of children and young people throughout their lives. In areas of social disadvantage this number can rise to 50% [19] [20] of all children and young people, including those with delayed language as well as children with identified SLCN.

1.13. Too many children and young people receive inadequate, ineffective and inequitable support because of poor understanding of, and insufficient resourcing for SLCN. Unaddressed SLCN impacts upon children's educational attainment, health and wellbeing and life chances. Support for cognitive and language skills in the first 1000 days of life is critical.

1.14. Adverse Childhood Experiences (ACEs) are stressful experiences occurring during childhood that directly harm a child (e.g. sexual or physical abuse) or affect the environment in which the grow up (e.g. growing up in a house with domestic violence, parental separation or incarceration of a parent/guardian). Recent evidence demonstrates that chronic traumatic stress in early life can alter a child's brain development, and can fundamentally alter the development of their nervous, hormonal and immunological system.

1.15. Evidence suggests that there is a 'dose-response relationship' between ACEs and poor physical health, mental health and social outcomes. Adverse childhood experiences are associated with lower levels of education and employment, and increased levels of poverty in adulthood.[21]

1.16. To tackle the issue of ACEs, a strategic shift towards prevention and early intervention is needed and this should begin with supporting good maternal health, promoting positive outcomes for both mother and child and a focus on the early years.

1.17. A whole family approach should be adopted, with a focus on positive parenting, to prevent and reduce the impact of ACEs. A Make Every Contact Count (MECC) approach should also be used to safeguard children. A balance is needed between providing universal services to all children (such as through health visiting teams) while also focusing additional resources on vulnerable children and marginalised groups. It is important that we take a whole systems approach to the ACE agenda with engagement from services across the life course, including the

education system.

1.18. ACEs can set a child on a health-harming life course by increasing their risk of adopting health-harming behaviours such as smoking, problem drinking, poor diet, low levels of exercise and risky sexual behaviours.[22] Such behaviours can lead to premature ill health through increasing risks of developing non-communicable diseases such as cancer, heart disease and diabetes.[23] There is also a strong association between ACEs and premature mortality. A recent study reported that men and women who have had two or more childhood adversities are at increased risk of early death by 57% and 80% respectively.[24] Furthermore, experiencing ACEs can have a long-term impact on mental health, increasing the risk of depression, anxiety and psychosis, and can negatively impact educational attainment, employment and involvement with the criminal justice system. [25,26,27] With such widespread impacts, ACEs represent an important issue that needs to be addressed and prioritised in research and in policy.

1.19. There is good practice to learn from. The Scottish Government set out its commitment to preventing and mitigating ACEs in the 2017/18 Programme for Government[28]. It aims to embed a focus on preventing ACEs and supporting the resilience of children and adults in overcoming early life adversity across public services, including education, health, justice and social work.

Recommendation: Health and social care professionals including GPs, midwives, health visitors, family support workers and social workers should be trained to identity prenatal and perinatal maternal problems early, to enable a targeted offer of more individualised support and signposting for those families with the greatest needs.

Recommendation: A whole family approach should be taken, that is proportionate to need, with a focus on positive parenting, to prevent and reduce the impact of adverse childhood experiences (ACEs). A national framework for addressing and reducing Adverse Childhood Experiences should be adopted.

Breastfeeding and childhood obesity

1.20. Breastfeeding is highly beneficial for both infant and mother and contributes to reducing health inequalities. Breastfeeding reduces the risk of infection during early childhood and has additional benefits including increased intelligence and protection against obesity in childhood and later life.[29] [30] Reasons for the UK's low breastfeeding rates are complex and include low levels of support and education on breastfeeding for mothers (particularly young mothers and those from deprived backgrounds), practical problems with initiating breastfeeding after birth, and social stigma.

1.21. The UNICEF Baby Friendly Initiative is an example of an evidence-base programme working with families to encourage breastfeeding. It is also important to ensure that children, particularly those that are breastfed, receive the recommended daily allowance of Vitamin D, to promote healthy bones and reduce the risk of musculoskeletal conditions in later life.[31]

1.19 The 2018 Scientific Advisory Committee on Nutrition (SACN) report on 'feeding in the first year of life' concluded that 'excess energy intake and weight gain is of concern in relation to the evidence on the prevalence and risk of overweight and obesity in childhood'.[32] Currently over 1 in 5 children start school overweight/obese with widening inequalities, hence in addition to support for breastfeeding support for appropriate formula-feeding, weaning (introduction of solids) and physical activity should also be considered.

Recommendation: A long-term plan is required with the support of all the UK governments, health agencies and health services to change the culture of breastfeeding so that women feel socially supported to breastfeed. Childhood obesity prevention should focus on promoting a healthy pattern of growth in the early years.

Immunisation and vaccination

1.20. Immunisation across the life course is vital for the prevention of many communicable diseases and their associated morbidity and mortality.[33] In 2015, Wales, Northern Ireland and Scotland met the World Health Organisation (WHO) target for having the full course of the 5-in-1 vaccine at 12 months; England fell below the target of 95% with 94.2% coverage.[34] The UK failed to meet the WHO target for uptake of the measles, mumps and rubella (MMR) vaccine by age five, averaging 89.2%.[35] Barriers to immunisation uptake include a lack of access to services and perceived medical contradictions. Low levels of immunisation are associated with socioeconomic deprivation and are commonly found amongst ethnic minority groups, refugees and children whose families are travellers. It is important to tailor interventions to increase vaccination uptake for different social and cultural groups and research is needed to understand why specific groups have lower uptake.[36] [37]

Mental Health

1.21. The early years play an essential role in shaping mental health through childhood and beyond. Half of all adult mental health problems start before the age of 14[38]. Greater investment is therefore needed in promoting good mental health and wellbeing in children and young people, and their parents, including early identification and prompt intervention for those who need support with better services across education, social care, youth justice and health.

2. Current spending and barriers to investment

2.1 There is a compelling case for investment nationally and locally; and many organisations and individuals are actively engaged in the cause. However, these calls are taking place in the context of public spending cuts, including to public health budgets, and there is a significant competition for investment in services. The ADPH will continue to argue for investment in prevention and public health to ensure children have the best start in life.

2.2 In England spending on public health will be cut by 9.7% by 2020/21, £331 million in cash terms in addition to the £200 million in-year cut in 2015/16. Although DsPH have been acting to manage these cuts without detriment to outcomes, they have reached the limit of available

efficiencies. Cuts to public health funding will limit the ability of local authorities to fund and deliver early intervention, prevention and universal services.

2.3 Helping children and young people to fulfil their potential is a key ambition of all councils, but our children's services are under increasing pressure. LGA analysis shows children's services are facing a £3 billion funding gap by 2025, demand for these services has also increased dramatically. Councils have worked hard to protect budgets for essential child protection services, but funding pressures have led to difficult decisions elsewhere, leaving children and young people unable to access support until they reach breaking point. This is manifested by less funding for prevention and early intervention resulting in increasing numbers and complexity of placements for complex needs.[39]

2.4 Cuts to children's services are counterproductive. This is because the return from investment in early years' prevention is not merely financial but also observable in health improvements across the life course. Wider cuts to local authority funding are also creating financial challenges which have an impact of the determinants of health such as inequalities. This will continue to be a challenge in areas like social care which is facing a £3.56m funding gap by 2025.[40] The LGA estimates that local government will be faced with a core funding gap of £5.5 billion by 2019/2.

Recommendation: Investment in public health must be increased. Cuts to public health budgets must be reversed and public health needs to be funded both sustainably and adequately in line with local population health need.

Recommendation: The Government should mitigate the impact of wider local authority funding cuts on the health of children and young people; for example, cuts to children's services.

Recommendation: The Government should review the reasons for the increasing number and cost of complex child placements and recognise the burden that this places on local authorities.

3. Local provision

3.1 In the context of the financial constraints on councils, a balance is needed between providing universal services to all children (such as through health visiting teams) while also focusing additional resources on vulnerable children and marginalised groups.

3.2 As well as the financial barriers, which we have touched upon, there are also workforce challenges. For example, particularly in relation to health visitors and increasing issues with recruitment.

3.3 The role of DsPH in delivering high-quality services for the first 1000 days of life is critical. DsPH are collaborative system leaders for integration, with a place at top-level discussions and decision making. They provide an objective perspective and can focus on the big picture. With a history of working in both the NHS and local authorities, they are often seen as able to span boundaries, trusted by both and with an understanding of both cultures. DsPH have a key leadership role in working across organisations, building partnerships and influencing.

3.4 Greater integration – focused on outcomes - is a priority for new models of delivery. This includes new and more integrated ways of working both 'internally' within the public health nursing provision across health visiting, school nursing and the family nurse partnership, and 'externally' to integrate pathways and links with broader local health and care systems. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS) offer an opportunity to achieve this.

3.5 Local areas are working towards closer alignment between public health and children's services. Several areas are restructuring the workforce to deliver the 0-19 model and are in the process of reviewing and developing pathways with a focus on ensuring the provision of early identification and prevention. Children's centres have a key role to play in ensuring the success of this approach.

3.6 A few areas have also looked at developing new health visitor specialist roles for Perinatal and Infant Mental Health, which links the wider health visitor team with the perinatal teams – a clear benefit from health visiting being a responsibility of local authorities. This will help to ensure that parents are identified early and that there is a more responsive joined up approach.

3.7 Other areas have looked at developing a specialist safeguarding team within the health visitor and school nursing service to support 0-19 services to identify and manage risk relating to safeguarding concerns.

3.8 Many areas have also explored innovative ways of utilising technology to improve access and support intervention and prevention. Digital services such as 'Your Space' and 'Family Assist' have been used to increase the reach of the service, provide health information and sign post to services. 'Chat Health' has also been used to link school nurses directly with young people in need.

Association of Directors of Public Health
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[1] Completed on behalf of the Association of the Directors of Public Health (ADPH) by a team led by the School of Health and Related Research (ScHARR) at the University of Sheffield. Four Nations Study http://www.adph.org.uk/wp-content/uploads/2018/07/Four-Nations-Study-Report.pdf

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